

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Galamgam, Crescencia (ARCH)	CHAPTER 100.1
Address: 94-1278 Peke Place, Waipahu, Hawaii 96797	Inspection Date: October 2, 2019 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food Sanitation</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Cleaning agents were stored in an unlocked container inside an unlocked kitchen cabinet, beneath the sink.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports</u> (b)(8) Notation of visits and consultations made to resident by other professional personnel as requested by the resident of the resident's physician or APRN</p> <p><u>FINDINGS</u> Medical visits on 12/5/18, 2/26/19, 2/28/19, 3/12/19, 5/21/19, and 5/30/19, were not noted in progress notes by primary care giver.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11.100.1-23 <u>Physical environment</u> (h)(3) All Type 1 ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety.</p> <p><u>FINDINGS</u> Single use hand towels were not available in the residents' bathroom.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____